Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:

A. Property Costs Ceiling:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs Ceiling:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs Ceiling:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

D. Total costs per diem ceiling (including return on equity):

Shall not exceed $ 239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed $267.02 for the Developmental Non-Ambulatory classes as of April 1, 1998. For subsequent rate semesters, these ceiling amounts shall be inflated forward based on one times the ICF/MR-DD inflation index

utilizing the same inflation methodology as used in calculating prospective rates. When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including return on equity.

Example:	Interim Cost	Percent to total	Ceiling
Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67
ROE	7.26	2.9	6.97
Total	250	100%	240

I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid and the Developmental Services Program Office.

I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in Section V.B. of this plan shall be refunded to AHCA. Underpayment as a

result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in Section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Medicaid and the Developmental Services Program Office.

J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/MR-DD Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in Section V.A.7. of this plan.

1. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any Condition of Participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set.

K. A provider's reimbursement for service provided under the Florida Medicaid Program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

L The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by

AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester October 1, 1998 through March 31, 1999, the same cost reports used in setting April 1, 1998 rates or the most current cost report received by the agency by August 1, 1998 shall be used.

2. Review and adjust each provider's cost report referred to in Section IV.N. above to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and return on equity or use allowance if applicable. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.

4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly Florida ICF/MR-DD Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.

6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that

they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet State or Federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and 1 percent threshold under the interim rate provisions in Section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider must furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in Step 5 above to reflect the allowable change in costs. For the October 1, 1998 rate semester the components for the operating and resident care costs shall be the base costs established for the April 1, 1998 rate semester.

7. Compare the operating and resident care cost per diems resulting from Step 6 with the respective per diems from Step 4 for each reimbursement class.

   (a) If the operating per diem for either reimbursement class from Step 4 is less than the respective operating per diem from Step 6, then establish the new operating base per diem as the per diem from Step 4 plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the Step 4 per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the

rate semester being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 30 days of a 183 day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the operating per diem from Step 4 is greater than the Step 6 per diem, then establish the new operating base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 inflated by the target rate factor.

(b) If the resident care per diem for either reimbursement class from Step 4 is less than the respective resident care per diem from Step 6 then establish the new resident care base per diem as the per diem from Step 4 plus an incentive calculated as 50 percent of the difference between the Step 4 per diem and the Step 6 per diem, not to exceed 3 percent of the Step 4 per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 30 days of a 183 day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the resident care per diem from Step 4 is greater than the Step 6 per diem, then establish the new resident care base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 inflated by the target rate factor.

c) If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of each class. This shall equalize the operating rate cost components and allow for more meaningful trend comparison between cost reporting periods.

8. The new base per diems for property and return on equity or use allowance shall be the per diems established in step 4 above.

9. Using the appropriate current base per diem for resident care and operating costs from Step 7 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:
Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective October 1, 1998, the prospective rate semester used in calculating the above fraction shall be the period October 1, 1998 through March 31, 1999.

10. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step 9 plus the current approved per diems for property and return on equity or use allowance, if applicable, from Step 8.

B. Base year ceilings for new providers in facilities with six beds or less:

1. Property costs per diems shall not be in excess of the ceiling limitations established in Section III. of this plan.

2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that have prospective rates. This ceiling shall be recalculated for every rate semester beginning April 1 and October 1 of each year.

3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate semester beginning April 1 and October 1 of each year.

4. Total costs per diem ceilings (including return on equity):
Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.2.D. multiplied times 1.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including return on equity, in the base year.

Example:	Interim Cost	Percent to total	Ceiling
Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67
ROE	7.26	2.9	6.97
Total	250	100%	240

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement

Plan for Facilities Not Publicly Owned and Not Publicly Operated (Formerly Known as ICF-MR/DD Facilities).

VII. Provider Participation

This plan is designed to assure adequate participation of ICF/MR-DD providers in the Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to an ICF/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15 (1997).

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

HCFA PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

DCF: Department of Children and Family Services, also known as the Department.

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

ICF/MR-DD Return on Equity or Use Allowance Costs: See Sections III.H. and III.I. of this plan.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.